IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3315 1934

August 1, 2008

Floyd D. Bounds
Teton Valley Hospital And Surgicenter
120 East Howard Avenue
Driggs, Idaho 83422

RE: Teton Valley Hospital And Surgicenter, provider #131313

Dear Mr. Bounds:

Based on the Complaint survey completed at Teton Valley Hospital And Surgicenter on July 30, 2008 by our staff, we have determined that Teton Valley Hospital And Surgicenter is out of compliance with the Medicare Hospital Conditions of Participation on Emergency Services (42 CFR 485.618) and Organizational Structure (42 CFR 485.627). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this condition to be unmet substantially limit the capacity of Teton Valley Hospital And Surgicenter to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **September 13, 2008. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than September 5, 2008.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

Also pursuant to the provisions of IDAPA 16.03.14.150.01.g, Teton Valley Hospital And Surgicenter is being issued a Provisional hospital license. The license is enclosed and is effective July 30, 2008, through November 30, 2008. The conditions of the provisional license are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware, that failure to comply with the conditions of the provisional license, may result in further action being taken against the hospital's license.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit to the State Survey Agency a written request by **August 28, 2008**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208)364-1804
fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/mlw

Enclosures

c: Steve Millward
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief

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BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 6, 2008

Certified Mail: 7000 1670 0011 3315 1965

Floyd D. Bounds
Teton Valley Hospital and Surgicenter
120 East Howard Avenue
Driggs, Idaho 83422

RE: Teton Valley Hospital and Surgicenter, provider #131313

Dear Mr. Bounds:

This letter is to inform you that after they were sent to you, errors were noted in the CMS-2567 listing federal Medicare certification deficiencies and State Form listing licensing deficiencies. To ensure clarity and avoid any confusion that may result from the errors, the errors have been corrected. The revised CMS-2567 and State Form are enclosed. **These will become the reports of record and the previously issued CMS-2567 will be destroyed. I ask that you also destroy the survey reports sent to you via certified mail on August 1, 2008.**

I am faxing the survey reports to you so you have them as soon possible. A hardcopies of the survey report forms will also be sent to you via certified mail. **Please use the attached forms when you submit your Credible Allegation of Compliance for the Medicare certification deficiencies and plan of correction for the licensing deficiencies. The time frames for correction remain the same as those identified in the August 1, 2008, letter.**

I apologize for any inconvenience brought about by the need to revise the survey reports. Thank you, in advance, for your understanding and cooperation. If you have further questions, please do not hesitate to me.

Sincerely,

Sylvia Creswell

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

Teton Valley Hospital
& Surgicenter
PARTNERS IN HEALTH FOR A LIFETIME

120 East Howard • Driggs, Idaho 83422 • (208) 354-2383 • (208) 354-3158 (fax)

9-3-08

Idaho Bureau of Facility Standards
ATT: Sylvia Creswell, Supervisor
3232 Elder Street
P O Box 83720
Boise, ID 83720-0036

Dear Ms. Creswell:

Enclosed are the responses to the critical allegations as referenced in your Statement of Deficiencies/Conditions of Participation (CMS-2567) in your letter of 8-6-08. These responses include our plan of correction wherein policies and procedures were developed, implemented and trained to pertinent staff as it relates to their job descriptions. Those policies and procedures include the following:

1. Administrator On Call
2. Facility Diversion
3. Provider Scheduling
4. Emergency Medical Screening Examination
5. Admission of the ED Patient
6. Director of Nursing Services Designee
7. Physician Back Up

The individuals involved in development of the above policies and procedures include the CEO, the CFO, the ED Medical Director, the Director of Nursing Services (DNS), the Director of Clinical Services, and the Director of Quality Services. Approval of the policies was finalized on August 25th, 2008 by the Governing Board.

Implementation and training was accomplished by the DNS, the CFO, and the Director of Clinical Services.

The Quality Improvement project to assure compliance to the plan of correction is overseen by the Director of Quality Improvement.

Completion dates are given at the side of the responses to the allegations.

Oversight of the plan of correction will be assured by myself, Floyd Bounds, CEO, and assisted by Laura Piquet, Director of Quality Services (Compliance Officer).

Additionally, we have included our response to the allegations from CMS.

If there is anything else we can to do to assist you in your review of our plan of correction, please let us know.

Most Sincerely,

Floyd D Bounds

Floyd D. Bounds,
Chief Executive Officer
(208) 354-6328

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131313	A. BUILDING _____ B. WING _____	C 07/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TETON VALLEY HOSPITAL AND SURGICENTER	120 EAST HOWARD AVENUE DRIGGS, ID 83422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Acronyms used on this report include: CEO = Chief Executive Officer DON = Director of Nursing ED = Emergency Department MSE = Medical Screening Examination PA = Physician Assistant RN = Registered Nurse	C 000	**Page 1 of 14:** RECEIVED SEP 04 2008 FACILITY STANDARDS	
C 200	485.618 EMERGENCY SERVICES The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients. This CONDITION is not met as evidenced by: Based on interviews of hospital staff and review of medical records and hospital policies, it was determined the hospital failed to provide emergency care to meet the needs of its patients. The hospital failed to provide basic emergency care to patients on 6/24/08 and had not taken corrective action to prevent the situation from recurring. The findings include: Refer to C201 as it relates to the failure of the hospital to provide emergency services during a 24 hour period. This resulted in the inability of the hospital to provide safe and timely emergency care.	C 200	**C200: Refer to C201**	9/3/08
C 201	485.618(a) AVAILABILITY	C 201		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Floyd N Bamsey	CEO	9/3/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 201	Continued From page 1 Emergency services are available on a 24-hours a day basis. This STANDARD is not met as evidenced by: Based on interviews of hospital staff and review of medical records and hospital policies, it was determined the hospital failed to have emergency services available during a 24 hour period. This resulted in at least 6 of 6 patients (#'s 19, 20, 21, 22, 23, and 26) who arrived at the ED on 6/24/08 not receiving medical evaluation and treatment at the hospital. Additional patients may have been affected. However, since the hospital had placed signs on the doors stating services were not available and since ED personnel did not enter the patient names into the ED Log for the day in question, it was not possible to confirm or deny that other patients were affected. Having emergency services unavailable delayed assessment, stabilization, and treatment and had the potential to cause negative patient outcomes in all patients who sought care at the ED during the time emergency services were unavailable. The findings include: During an interview on 7/23/08 at 2 PM, the DON confirmed that the hospital went on formal divert status, beginning 8 AM on 6/24/08 until 8 AM on 6/25/08. Patients who arrived at the hospital seeking care were referred by the RN to rural health clinics associated with the hospital and/or to other hospital EDs. A sign was posted on at least 2 entrances to the hospital which stated "Teton Valley Hospital is currently on diversion for our Emergency Services. You can be seen in our [local] Clinics. If it is an emergency, we will make arrangements for you to be transported to [other regional hospitals]." The alternate hospitals were located at distances of 34 to 75 miles away and	C 201	**Page 2 of 14:** **C201:** We have developed and implemented the following policies/procedures to become compliant with the requirement to have emergency room services available 24/7. 1. **Facility Diversion P/P** which provides the requirements, limitations, and processes for appropriate facility diversion. 2. **Provider Scheduling P/P and Physician Back Up P/P**: which mandates daily schedules for our ED/Hospitalist and Clinic coverage and the requirements to have 24/7 physician back up/coverage. It also covers time off requirements/limitations. 3. **Admission of ED Patient P/P:** which sets the guidelines for how ED patients are admitted into the medical record system. No payment information will be requested until the patient has had a MSE and is stabilized. It also mandates that all patients will be logged in the ED Log book, regardless of the extent of care required.	9-3-08 9-3-08 9-3-08 9-3-08

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C 201	Continued From page 2 had to be accessed over mountain roads with an estimated drive time of greater than 45 minutes. This diversion from the ED was confirmed during separate interviews by multiple hospital staff, including the Director of Quality Services, the Director of Clinical Support Services, the CEO, the ED Coordinator, and additional staff RNs. When asked during an interview, on 7/24/08 at 9:45 AM, how and why the diversion happened, the Director of Clinical Support Services explained that there had been a "hole in the ED schedule" for 4 weeks. He said he had been trying for weeks to get the 24-hour shift covered but could not find a physician willing or able to work the shift. Minutes of a medical staff meeting dated 4/29/08 documented discussion regarding potential scheduling issues. The minutes read as follows: "[name] came to discuss issues with the medical staff scheduling for the ER and [name] and [name] clinics. He did a power point demonstration of areas where the clinic staff was extremely low in numbers and often left clinics with only one provider all day. It appears that the clinic staff is being pulled to cover 24/7 ER coverage, thereby diminishing patient care in the clinics. Review of the situation found it to be more a staffing issue than a scheduling issue as the numbers are not adequate to cover both the ER and the clinic, especially if vacations or time off is requested by anyone. Plans are to meet on May 6th at 7:00 am to discuss scheduling. All providers, including the mid-levels will need to attend or have someone else represent their needs at that meeting. Providers are asked to bring time off requests for vacation, holidays and time off for at least the end of August but	C 201	**C021**: continued. (Page 3 of 14) **Provider Scheduling P/P and Physician Back up P/P** address the requirements of covering ED 24/7 with physician coverage/back up. A need for clarification concerning the statements in the Medical Staff meeting, dated 4-29-08, wherein it was written that a meeting to discuss scheduling was planned for 5-6-08: This was not a medical staff meeting. It was just a informal meeting where in members of the medical staff and their scheduler, met to discuss scheduling issues. It was not a formal medical staff meeting and therefore did not require the taking of minutes	9-3-08 9-3-08

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C 201	Continued From page 3 preferably for the next 6 months. Holidays need to be decided for the rest of the year if possible. Administration has emphasized that we cannot have all 7 or 8 providers off at the same time because it affects patient care and it is unfair to the provider(s) left to cover. May need to consider flexible dates and non-flexible dates and other possible scheduling models." When asked during an interview on 7/23/08 at 11:30 AM about the the follow-up meeting held on May 6th, the Director of Clinical Support Services stated that an informal "pizza meeting" was held to further discuss the scheduling needs. He stated that he was unable to fill the hole in the schedule on 6/24/08, the day of the diversion. No meeting minutes were reportedly available for the meeting. During an interview on 7/23/08 at 2:15 PM, RN A, who worked 7 AM to 7 PM in the ED on the day of the diversion (6/24/08), stated she thought "four or five" patients came to the hospital during her shift. She stated that she provided a nursing assessment, including listening to their concerns and taking their vital signs. She then reportedly referred patients to the rural health clinic associated with the hospital for medical evaluation and treatment as the hospital did not have a provider available. The Director of Clinical Support Services provided a list that included the names of five patients (#'s 19, 20, 21, 22, and 23) who arrived at the ED seeking emergency services on 6/24/08 and were subsequently diverted to a rural health clinic associated with the hospital for medical evaluation and treatment. Details regarding the five patients follow. Patient #19 was a 21 year old male who	C 201	**C 201:** continued (Page 4 of 14) Please see the policies as listed below that address scheduling policies and procedures and limitations on number of providers taking planned time off: 1. **Provider Scheduling P/P** 2. **Physician Back up P/P** See **Admission of ED Patient P/P** which addresses the need for documentation and entry of all patients presenting to the ED for care in the ED Log. **Facility Diversion Policy/Procedure** addresses the requirements of a diversion and staff has been informed of the requirements of such. All P & P are available on our computerized system for staff to refer to at all times	9-3-08 9-3-08 9-3-08

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C 201	Continued From page 4 presented to the ED on 6/24/08 at 8:00 AM. The RN documented the patient's vital signs, including a blood pressure of 145/77 and a pulse of 68, in the ED records. The accompanying ED note stated the patient had shot himself in the thumb with a nail gun and that the PA was "coming to see (patient) and then will treat in clinic." The clinic note documented that the PA examined the patient in the ED, cleaned the wound, and then referred the patient to a physician at a hospital 47 miles away. The PA documented the encounter as an "Office Procedure" and the location of care as "OP" (outpatient) at the hospital. While an examination was documented in the ED record, the PA, who was interviewed on 7/22/08 at 4:20 PM, stated she did not provide emergency services to this patient at the hospital on 6/24/08. Patient #20 was a 19 year old female who presented to the ED on 6/24/08 at 5:45 PM. The RN documented the patient's vital signs, including a blood pressure 162/93 and a pulse of 104, in the ED record. The accompanying ED note stated the patient "walked in (complaining of) 'stomach upset' spitting blood [with] was directed to a rural health clinic associated with the hospital. The PA documented in the clinic note, dated 6/24/08, that the patient complained of "coughing up blood and mucus for about a week, a couple times a day." She was diagnosed with "GASTRITIS NEC W/HEMORRHAGE". Further tests (laboratory, ultrasound) were recommended at other facilities. No documentation was found to indicate the hospital provided medical evaluation or treatment prior to diverting Patient #20 to the rural health clinic. Patient #21 was an 8 year old female who presented to the ED on 6/24/08 with an achy body	C 201	**C 201:** continued (page 5 of 14) **Facility Diversion Policy/Procedure** addresses the requirements of a diversion and staff has been informed of the requirements of such. P & P are available on our computerized system for staff to refer to at all times. **See Emergency Medical Screening Examination P/P.** Policy states that all patients will receive a Medical Screening Examinatin (MSE) by a Medical Staff Provider when they present to the ED. Documentation is recorded in the ED medical record.	9-3-08 9-3-08

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C 201	Continued From page 5 and a fever. No documentation was found as to the time of arrival in the ED. The clinic note, dated 6/24/08, documented a nursing assessment at 5:17 PM. The clinic note further documented that the patient was treated for an ear infection and sent home with instructions to return to the clinic in one day. No documentation was found to indicate the hospital provided medical evaluation or treatment prior to diverting Patient #21 to the rural health clinic. Patient #22 was a 30 year old female who presented to the ED on 6/24/08 with a swollen foot after a bicycle accident the previous day. No documentation was found as to the time of arrival in the ED. The clinic note, dated 6/24/08 documented a nursing assessment at 5:44 PM. The clinic note further documented the x-ray results were negative for a fracture and that the patient was sent home with instructions for how to manage pain and swelling and further advised to return to the clinic if symptoms continued or worsened. No documentation was found to indicate the hospital provided evaluation and treatment prior to diverting Patient #22 to the rural health clinic. Patient #23 was a 31 year old female who presented to the ED on 6/24/08 with a wound to her foot after having stepped on a garden rake. No documentation was found in the clinical record as to the time of arrival in the ED. A clinic note, dated 6/24/08 documented a nursing assessment at 10:54 AM. The clinic note further documented: 1) the patient's wound was treated; 2) she was given a tetanus shot; 3) she was sent home with instructions to return to the clinic in one day for a wound check and wound care instructions. No documentation was found to indicate the hospital	C 201	**C 201**: continued (Page 6 of 14) See **Admission of the ED Patient P/P** which addresses documentation requirements. See **Emergency Medical Screening Examination P/P** wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record. See **Emergency Medical Screening Examination P/P** wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record	9-3-08 9-3-08 9-3-08

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C 201	Continued From page 6 provided evaluation and treatment prior to diverting Patient #23 to the rural health clinic. An additional unknown patient (#26) was reportedly diverted away from the ED after seeking emergency care. During an interview on 7/23/08 at 2:37 PM, RN B, who worked 7 PM to 7 AM during the diversion on 6/24/08 and 6/25/08, stated that one adult female patient complaining of abdominal pain arrived at the ED during her shift. The RN stated: 1) she did not take the patient's vital signs; 2) she did not do any hands-on assessment; 3) she did not get the woman's name; 4) she told the patient that no physician was available to see her in the hospital and that she (the patient) could go to another hospital or be seen in the clinic in the morning. The patient reportedly left with her husband to find another emergency facility. No ED clinical record was found to confirm or deny the information provided by the RN. During an interview on 7/24/08 at 9:30 AM, the Director of Quality Services denied that any formal analysis had been done by the hospital related to the diversion that occurred on 6/24/08. She denied that any policies or procedures regarding going on diversion were in place prior to the diversion, nor had any new policies and procedures relating to the diversion been established since the diversion. She also denied that any performance improvement activities had been initiated related to the diversion. Similarly, during an interview on 7/23/08 at 11:35 AM, the Director of Clinical Support Services stated that no formal meetings had been held and no specific action had been taken to prevent the need for the hospital to go on divert in the future. He also stated that no action had been taken to ensure	C 201	**C201**: (Page 7 of 14) See **Admission of the ED Patient P/P** which addresses documentation requirements. Medical Staff met on Aug 19, 2008 and reviewed and discussed issues relating to Diversion of 6-24-08. Agreed to the formation of the polices as listed below. Governing Board meeting was held on August 25th, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies: 1. **Administrator On-Call P/P** 2. **Facility Diversion P/P** 3. **Provider Scheduling P/P** 4. **Emergency Medical Screening Examination P/P** 5. **Admission of the ED Patient P/P** 6. **Director of Nursing Services Designee P/P** 7. **Physician Back Up P/P**	9-3-08 9-3-08

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C 201	Continued From page 7 patients would be provided with appropriate MSEs should the hospital go on divert again. In summary, the agency failed to have available 24-hour emergency services during one 24 hour period in June, 2008.	C 201	**C 201**: Continued. (Page 8of 14)	
C 240	485.627 ORGANIZATIONAL STRUCTURE Organizational Structure This CONDITION is not met as evidenced by: Based on interviews of hospital staff and review of medical records and hospital policies, it was determined the hospital failed to ensure the organizational structure of the hospital was sufficient to maintain basic services. The hospital failed to ensure the governing body including the CEO provided sufficient direction to staff to provide emergency services and failed to ensure corrective action was taken to prevent future abscences of care. The findings include: Refer to C241 as it relates to the failure of the hospital to ensure the governing body, including the CEO, assumed responsibility for determining and implementing policies governing emergency services at the hospital. This resulted in the inability of the hospital to provide safe and timely emergency care and to react to future staffing crises.	C 240	**C240: Refer to C 241.**	
C 241	485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered	C 241	**C 241: See next page**	

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	131313	A. BUILDING _____ B. WING _____	C 07/30/2008

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TETON VALLEY HOSPITAL AND SURGICENTER	120 EAST HOWARD AVENUE DRIGGS, ID 83422

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C 241	Continued From page 8 so as to provide quality health care in a safe environment. This STANDARD is not met as evidenced by: Based on review of clinical records and hospital policies and interviews with hospital staff, it was determined the hospital failed to ensure the governing body, including the CEO, assumed responsibility for determining and implementing policies governing emergency services at the hospital. The governing body failed to ensure emergency services were provided on a continuous and consistent basis and failed to provide direction to staff when physician coverage was not available at the hospital. This affected the care of at least 6 of 6 patients (#'s 19, 20, 21, 22, 23, and 26), who came to the ED on 6/24/08 during the time the hospital was on formal diversion status. It also affected the care of one patient (#17) who was transferred to another hospital when Teton Valley Hospital went on divert. As a result, there was a delay in evaluation, stabilization, and/or treatment to patients arriving at the ED on 6/24/08. This had the potential to cause negative patient outcomes in all patients who sought care at the ED during the time emergency services were unavailable. The findings include: 1. The hospital went on divert status, beginning at 8 AM on 6/24/08 and lasting until 8 AM on 6/25/08, for both inpatients and patients seeking emergency care at the ED. This diversion was confirmed during separate interviews by multiple hospital staff, including the Director of Quality Services, the Director of Clinical Support Services, the CEO, the ED Coordinator, the DON, and additional staff RNs. A sign was posted on at	C 241	**C241: (Page 9 of 14)** Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies: **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back Up P/P** Implementation is evidenced by: 1) Creation of the above-listed policies and procedures. 2) Physician Schedule being posted and back up assured on a continual basis. 3) AOC Training 4) AOC Log Book implementation 5) Development of Crisis Calling Checklist 6) ED Admission Training 7) Notification to Patient concerning Provider Coverage 24/7. 8) Quality Improvement review project to assure ED patients are being placed on the ED log as well as assuring MSEs are done on all ED patients	9-3-08

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C 241	Continued From page 9 least 2 entrances to the hospital which read "Teton Valley Hospital is currently on diversion for our Emergency Services. You can be seen in our [local] Clinics. If it is an emergency, we will make arrangements for you to be transported to [other regional hospitals]." The alternate hospitals were located at a distance of 34 to 75 miles away and had to be accessed over mountain roads with an estimated drive time of greater than 45 minutes. One patient (#17), an 82 year old female with back pain who presented to the ED on 6/23/08 at 7:10 PM, was transferred to an alternate hospital for inpatient admission in anticipation of the hospital going on divert the following day. Another inpatient was discharged normally on the morning of 6/24/08. No inpatients were present during the time the hospital was on divert. Following the event, the hospital had not analyzed the causes of the diversion and had not taken steps to minimize the impact on patients and services if a physician was not available to the hospital at a future date. 2. The Chief of the Medical Staff was interviewed on 7/30/08 at 8:40 AM. He stated he had met with physicians as far back as February 2008 and had told administrative personnel there were not enough physicians to provide hospital coverage. He said he warned administrative personnel that, due to vacations and other time conflicts, there might be days in the summer when a physician would not be available to provide hospital services. He said he was the physician on duty from 6/23/08 until 6/24/08 at 8:00 AM. A physician was not available from 6/24/08 at 8:00 AM until 6/25/08 at 8:00 AM. The Chief of the Medical Staff stated the hospital went on divert during that time. He stated he met with the CEO and other administrative staff at 7:00 AM on	C 241	**C 241: (Page 10 of 14)** **Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the Floyd Bounds, CEO who has assisted with the development and implementation of these policies:** **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back Up P/P** Implementation is evidenced by: 1. Creation of the above-listed policies and procedures. 2. Physician Schedule being posted and back up assured on a continual basis. 3. AOC Training 4. AOC Log Book implementation 5. Development of Crisis Calling Checklist 6. ED Admission Training 7. Notification to Patient concerning Provider Coverage 24/7. 8. Quality Improvement review project to assure ED patients are being placed on the ED log, as well as assuring MSEs are done on all ED patients. Medical Staff met on Aug 19, 2008 and reviewed and discussed issues relating to Diversion of 6-24-08.	9-3-08

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C 241	Continued From page 10 6/24/08. He stated he was told by the administrative team that going on divert was standard business practice. He said he believed the hospital had a plan to ensure patients would be provided at least with medical screening examinations while on divert but he said he did not know what that plan was. Two Medical Staff meetings had been held since the hospital went on divert, an ED Committee meeting on 7/10/08 and a Medical Staff meeting on 7/15/08. He said administrative staff told physicians at these meetings that the diversion of hospital patients on 6/24/08 "went fine". He said the medical staff did not discuss the diversion, either how the diversion was handled or what might be done differently in the future if physician coverage was not available to the hospital. 3. The CEO was interviewed on 7/23/08 at 9:10 AM. He stated there had been a lack of physicians to cover the hospital. He confirmed the hospital had gone on divert on 6/24/08. He stated there was no policy or procedure directing staff what to do in this situation. He acknowledged the sign posted on the hospital's doors. He stated after the event, that he, the DON, and the Director of Clinical Services had informally discussed how things had gone the day of the diversion but said no formal analysis of the event had taken place. He said there were no minutes of the above meeting. He stated physician staffing had not changed since the event. He said no policies or procedures had been developed to provide direction to staff if the situation recurred. The CEO failed to ensure the hospital had developed plans to provide services to patients during this predicable situation. The CEO also failed to ensure patients would receive basic hospital care and services.	C 241	**C 241**: continued. (Page 11 of 14) Medical Staff met on Aug 19, 2008 and reviewed and discussed issues relating to Diversion of 6-24-08. Agreed to the formation of the policies as listed directly above. Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies: 1. **Administrator On-Call P/P** 2. **Facility Diversion P/P** 3. **Provider Scheduling P/P** 4. **Emergency Medical Screening Examination P/P** 5. **Admission of the ED Patient P/P** 6. **Director of Nursing Services Designee P/P** 7. **Physician Back up P/P**	9-3-08

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C 241	Continued From page 11 4. Staff C was a PA who worked in a rural health clinic attached to the hospital on 6/24/08. She was interviewed on 7/23/08 at 4:20 PM. She had worked as the provider in the ED with physician back up, both before and after 6/24/08. She stated, when the hospital went on divert, that she was told by the Director of Clinical Services, that she would be accepting patients in the clinic that day that were diverted from the ED. She said it was her understanding that, if a patient presented to the ED as emergent, that she (the PA) would not be allowed to participate in the decision making, would not be providing a MSE to the patient, and would not see the patient in the hospital. She expressed feelings of frustration and discomfort at the possibility of someone coming in to the ED but not receiving emergent care. She stated it would be illegal for her to provide emergent care at the ED because she did not have physician back-up available. She stated it was her understanding that she could not respond to a heart attack or a severe allergic reaction without defying instructions given to her by administrative staff. The governing body, including the CEO, had not ensured the PA was afforded sufficient direction to provide safe and effective patient care. 5. Staff B, an RN, was interviewed on 7/23/08 at 2:37 PM. She stated she had worked 7 PM to 7 AM during the diversion on 6/24/08 and 6/25/08. The RN stated she had been instructed by the Director of Clinical Services to treat patients as if it was a 24 hour clinic setting. She said she was not to allow patients into the ED because they were not ED patients. Instead, she stated she was told to get a copy of the patient's insurance information and let the clinic see the patient in the	C 241	**C 241**: Continued (Page 12 of 14) **Facility Diversion Policy/Procedure** addresses the requirements of a diversion and staff has been informed of the requirements of such. P & P are available on our computerized system for staff to refer to at all times. See also **Emergency Medical Screening Examination P/P** wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record **Admission of ED Patient P/P:** which sets the guidelines for how ED patients are admitted into the medical record system. No payment information will be requested until the patient has had a MSE and is stabilized. It also mandates that all patients will be logged in the ED Log book, regardless of the extent of care required.	9-3-08 9-3-08 9-3-08

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C 241	Continued From page 12 morning. Nurse B stated an adult female (Patient #26) came to the hospital after 11 PM on 6/24/08, complaining of abdominal pain. The nurse stated Patient #26 was diverted away from the ED after seeking emergency care. Nurse B stated she did not take the patient's vital signs, did not conduct a hands-on assessment, and did not get the woman's name. She stated she explained to the patient that no physician was available and that the patient could go to another hospital or be seen in the clinic in the morning. The patient reportedly left with her husband to find another emergency facility. The governing body, including the CEO, had not ensured the RN was afforded sufficient direction to provide safe and effective patient care. 6. Nurse A, an RN who worked 7 AM to 7 PM in the ED on the day of the diversion (6/24/08), was interviewed on 7/23/08 at 2:15 PM. She said she was told her responsibility as the ED nurse was to conduct a nursing assessment of the patient. If she decided the patient needed physician services, she would offer to transfer them to another ED. She said if she determined the patient only needed clinic services, she would direct them to a rural health clinic. Nurse A stated she thought "four or five" persons came to the hospital during her shift. She stated that she provided them with a nursing assessment, including listening to their concerns and taking their vital signs. She said she referred the patients to the clinic attached to the hospital for medical evaluation and treatment. She said these patients were not seen in the hospital by a provider. The direction given to Nurse A was different than the direction given to Nurse B. The governing body, including the CEO, failed to ensure nurses were provided with consistent	C 241	**C 241**: continued. (Page 13 of 14) **Admission of ED Patient P/P:** which sets the guidelines for how ED patients are admitted into the medical record system. No payment information will be requested until the patient has had a MSE and is stabilized. It also mandates that all patients will be logged in the ED Log book, regardless of the extent of care required **Facility Diversion Policy/Procedure** addresses the requirements of a diversion and staff has been informed of the requirements of such. P & P are available on our computerized system for staff to refer to at all times. See also **Emergency Medical Screening Examination P/P** wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record	9-3-08 9-3-08 9-3-08

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C 241	Continued From page 13 instructions regarding how to manage patients. 7. At least 6 patients (#'s 19, 20, 21, 22, 23, 24, and 26) presented to the hospital on 6/24/08 and were denied care. Refer to C201 as it relates the the failure of the hospital to provide care to these patients.	C 241	**C241**: Continued. (Page 14 of 14) Medical Staff met on Aug 19, 2008 and reviewed and discussed issues relating to Diversion of 6-24-08. Agreed to the formation of the polices as listed below. Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies: **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back up P/P** Implementation is evidenced by: 1. Creation of the above-listed policies and procedures. 2. Physician Schedule being posted and back up assured on a continual basis. 3. AOC Training 4. AOC Log Book implementation 5. Development of Crisis Calling Checklist 6. ED Admission Training 7. Notification to Patient concerning Provider Coverage 24/7. 8. Quality Improvement review project to assure ED patients are being placed on the ED log. MSE adherence will also be evaluated.	9-3-08

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B 000	16.03.14 Initial Comments The following state licensure deficiencies were cited during the complaint investigation of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Acronyms used on this report include: CEO = Chief Executive Officer DON = Director of Nursing ED = Emergency Department MSE = Medical Screening Examination NP = Nurse Practitioner PA = Physician Assistant RN = Registered Nurse	B 000	RECEIVED SEP 04 2008 FACILITY STANDARDS **BB115**: Page 1 of 16) Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies: **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back up P/P**	9-3-08
BB115	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88) a. Membership of Governing Body, which consist of: (12-31-91) i. Basis of selecting members, term of office, and duties; and. (10-14-88)	BB115		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Edward J Bamond — TITLE: CEO — (X6) DATE: 9/3/08

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BB115	Continued From page 1 ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and	BB115	**BB 115: continued. (Page 2 of 16)** See page 1.	9-3-08

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BB115	Continued From page 2 reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88) v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88) e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88)	BB115	**BB 115: continued. (Page 3 of 16)** See page 1.	9-3-08

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BB115	Continued From page 3 i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88) This Rule is not met as evidenced by: Based on review of clinical records and hospital policies and interviews with hospital staff, it was determined the hospital failed to ensure the governing body assumed responsibility for determining and implementing policies governing emergency services at the hospital. The governing body failed to ensure emergency services were provided on a continuous and consistent basis and failed to provide direction to staff when physician coverage was not available at the hospital. This affected the care of at least 6 of 6 patients (#'s 19, 20, 21, 22, 23, and 26), who came to the ED on 6/24/08 during the time the hospital was on formal diversion status. It also affected the care of one patient (#17) who was transferred to another hospital when Teton Valley Hospital went on divert. As a result, there	BB115	**BB 115: continued. (Page 4 of 16)** Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies: **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back up P/P**	9-3 08

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB115	Continued From page 4 was a delay in evaluation, stabilization, and/or treatment to patients arriving at the ED on 6/24/08. This had the potential to cause negative patient outcomes in all patients who sought care at the ED during the time emergency services were unavailable. In addition, the governing body failed to enforce bylaws which specified every patient must be under the care of a physician. This resulted in a lack of physician services provided to 1 of 1 inpatients (#24) whose record was reviewed. The findings include: 1. The hospital went on divert status, beginning at 8 AM on 6/24/08 and lasting until 8 AM on 6/25/08, for both inpatients and patients seeking emergency care at the ED. This diversion was confirmed during separate interviews by multiple hospital staff, including the Director of Quality Services, the Director of Clinical Support Services, the CEO, the ED Coordinator, the DON, and additional staff RNs. A sign was posted on at least 2 entrances to the hospital which read "Teton Valley Hospital is currently on diversion for our Emergency Services. You can be seen in our [local] Clinics. If it is an emergency, we will make arrangements for you to be transported to [other regional hospitals]." The alternate hospitals were located at a distance of 34 to 75 miles away and had to be accessed over mountain roads with an estimated drive time of greater than 45 minutes. One patient (#17), an 82 year old female with back pain who presented to the ED on 6/23/08 at 7:10 PM, was transferred to an alternate hospital for inpatient admission in anticipation of the hospital going on divert the following day. Another inpatient was discharged normally on the morning of 6/24/08. No inpatients were present during the time the hospital was on divert. Following the event, the hospital had not analyzed the causes of the	BB115	**BB 115**: continued (Page 5 of 16) **Provider Scheduling P/P and Physician Back up P/P** address the requirements of covering ED 24/7 with physician coverage/back up. **1) Facility Diversion Policy/Procedure** addresses the requirements of a diversion and staff has been informed of the requirements of such. P & P are available on our electronic policy program for staff to refer to at all times now.	9-3-08 9-3-08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131313	A. BUILDING _____ B. WING _____	C 07/30/2008

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BB115	Continued From page 5 diversion and had not taken steps to minimize the impact on patients and services if a physician was not available to the hospital at a future date. 2. The Chief of the Medical Staff was interviewed on 7/30/08 at 8:40 AM. He stated he had met with physicians as far back as February 2008 and had told administrative personnel there were not enough physicians to provide hospital coverage. He said he warned administrative personnel that, due to vacations and other time conflicts, there might be days in the summer when a physician would not be available to provide hospital services. He said he was the physician on duty from 6/23/08 until 6/24/08 at 8:00 AM. A physician was not available from 6/24/08 at 8:00 AM until 6/25/08 at 8:00 AM. The Chief of the Medical Staff stated the hospital went on divert during that time. He stated he met with the CEO and other administrative staff at 7:00 AM on 6/24/08. He stated he was told by the administrative team that going on divert was standard business practice. He said he believed the hospital had a plan to ensure patients would be provided at least with medical screening examinations while on divert but he said he did not know what that plan was. Two Medical Staff meetings had been held since the hospital went on divert, an ED Committee meeting on 7/10/08 and a Medical Staff meeting on 7/15/08. He said administrative staff told physicians at these meetings that the diversion of hospital patients on 6/24/08 "went fine". He said the medical staff did not discuss the diversion, either how the diversion was handled or what might be done differently in the future if physician coverage was not available to the hospital. 3. The CEO was interviewed on 7/23/08 at 9:10 AM. He stated there had been a lack of	BB115	**BB 115**: continued (page 6 of 16) 2) Medical Staff met on Aug 19, 2008 and reviewed and discussed issues relating to Diversion of 6-24-08. Agreed to the formation of the polices as listed below. **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back up P/P**	9-3-08

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BB115	Continued From page 6 physicians to cover the hospital. He confirmed the hospital had gone on divert on 6/24/08. He stated there was no policy or procedure directing staff what to do in this situation. He acknowledged the sign posted on the hospital's doors. He stated after the event, that he, the DON, and the Director of Clinical Services had informally discussed how things had gone the day of the diversion but said no formal analysis of the event had taken place. He said there were no minutes of the above meeting. He stated physician staffing had not changed since the event. He said no policies or procedures had been developed to provide direction to staff if the situation recurred. The CEO failed to ensure the hospital had developed plans to provide services to patients during this predicable situation. The CEO also failed to ensure patients would receive basic hospital care and services. 4. Staff C was a PA who worked in a rural health clinic attached to the hospital on 6/24/08. She was interviewed on 7/23/08 at 4:20 PM. She had worked as the provider in the ED with physician back up, both before and after 6/24/08. She stated, when the hospital went on divert, that she was told by the Director of Clinical Services, that she would be accepting patients in the clinic that day that were diverted from the ED. She said it was her understanding that, if a patient presented to the ED as emergent, that she (the PA) would not be allowed to participate in the decision making, would not be providing a MSE to the patient, and would not see the patient in the hospital. She expressed feelings of frustration and discomfort at the possibility of someone coming in to the ED but not receiving emergent care. She stated it would be illegal for her to provide emergent care at the ED because she did not have physician back-up available. She stated	BB115	**BB 115**: continued (page 7 of 16) **3) Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies:** **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back up P/P** **4) Facility Diversion Policy/Procedure addresses the requirements of a diversion and staff has been informed of the requirements of such. P & P are available on our computerized system for staff to refer to at all times. See also Emergency Medical Screening Examination P/P wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record**	9-3-08 9-3-08

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BB115	Continued From page 7 it was her understanding that she could not respond to a heart attack or a severe allergic reaction without defying instructions given to her by administrative staff. The governing body, including the CEO, had not ensured the PA was afforded sufficient direction to provide safe and effective patient care. 5. Staff B, an RN, was interviewed on 7/23/08 at 2:37 PM. She stated she had worked 7 PM to 7 AM during the diversion on 6/24/08 and 6/25/08. The RN stated she had been instructed by the Director of Clinical Services to treat patients as if it was a 24 hour clinic setting. She said she was not to allow patients into the ED because they were not ED patients. Instead, she stated she was told to get a copy of the patient's insurance information and let the clinic see the patient in the morning. Nurse B stated an adult female (Patient #26) came to the hospital after 11 PM on 6/24/08, complaining of abdominal pain. The nurse stated Patient #26 was diverted away from the ED after seeking emergency care. Nurse B stated she did not take the patient's vital signs, did not conduct a hands-on assessment, and did not get the woman's name. She stated she explained to the patient that no physician was available and that the patient could go to another hospital or be seen in the clinic in the morning. The patient reportedly left with her husband to find another emergency facility. The governing body, including the CEO, had not ensured the RN was afforded sufficient direction to provide safe and effective patient care. 6. Nurse A, an RN who worked 7 AM to 7 PM in the ED on the day of the diversion (6/24/08), was interviewed on 7/23/08 at 2:15 PM. She said she was told her responsibility as the ED nurse was to conduct a nursing assessment of the patient. If	BB115	**BB 115**: continued (page 8 of 16) **5) Facility Diversion Policy/Procedure** addresses the requirements of a diversion and staff has been informed of the requirements of such. P & P are available on our computerized system for staff to refer to at all times. **Admission of ED Patient P/P:** which sets the guidelines for how ED patients are admitted into the medical record system. No payment information will be requested until the patient has had a MSE and is stabilized. It also mandates that all patients will be logged in the ED Log book, regardless of the extent of care required **6) See Emergency Medical Screening Examination P/P** wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record	9-3-08 9-3-08 9-3-08

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BB115	Continued From page 8 she decided the patient needed physician services, she would offer to transfer them to another ED. She said if she determined the patient only needed clinic services, she would direct them to a rural health clinic. Nurse A stated she thought "four or five" persons came to the hospital during her shift. She stated that she provided them with a nursing assessment, including listening to their concerns and taking their vital signs. She said she referred the patients to the clinic attached to the hospital for medical evaluation and treatment. She said these patients were not seen in the hospital by a provider. The direction given to Nurse A was different than the direction given to Nurse B. The governing body, including the CEO, failed to ensure nurses were provided with consistent instructions regarding how to manage patients. 7. At least 6 patients (#'s 19, 20, 21, 22, 23, and 26) presented to the hospital on 6/24/08 and were denied care. Refer to C201 as it relates the the failure of the hospital to provide care to these patients. 8. Hospital Bylaws, Rules and Regulations, dated February 1992, stated "2. A patient may be admitted to the hospital only by a physician member of the medical staff." This bylaw had not been followed for 1 of 1 patient (#24) whose record was reviewed. Patient #24 was an 82 year old female who was admitted to the hospital on 7/22/08 and was a patient as of 7/24/08. According to the admitting history and physical, she was admitted with "...right lower lobe multiple small emboli [blood clots]". She had a history of 2 strokes and hypertension. Her blood pressure on admission was 215/65 and her oxygen saturation levels were 69% on room air. (Normal is greater than 90%). She had to be placed on	BB115	**BB 115**: continued (page 9 of 16) **7) Governing Board meeting was held on August 25th, 2008, wherein the Diversion issue was discussed and the policies and procedures listed below were approved. These polices are also approved by the CEO who has assisted with the development and implementation of these policies:** **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back up P/P** **8) Provider Scheduling P/P and the Physician Back Up P/P addresses our commitment to provide 24/7 physician coverage and/or backup of midlevels.**	9-3-08 9-3-08

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BB115	Continued From page 9 oxygen at 10 liters per minute in order to keep her oxygen saturation levels above 90%. She was admitted by a NP and followed by the same NP. No documentation by a physician was present in the patient's record. Staff D, the NP caring for Patient #24, was interviewed on 7/24/08 at 11:55 AM. She stated she was not aware of a physician had visiting, examining, or treating the patient.	BB115	**BB 298** (page 10 of 16) **Provider Scheduling P/P and Physician Back Up P/P**: which mandates daily schedules for our ED/Hospitalist and Clinic coverage and the requirements to have 24/7 physician back up/coverage. It also covers time off requirements/limitations.	9-3-08
BB298	16.03.14.370.02 Staffing 02. Staffing. There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: (10-14-88) a. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed. (10-14-88) b. A qualified registered nurse shall be on duty in the facility and available to the emergency room at all times. (10-14-88) This Rule is not met as evidenced by: Based on interviews of hospital staff and review of medical records and hospital policies, it was determined the hospital failed to ensure adequate medical personnel were available to provide emergency services during a 24 hour period. This resulted in at least 6 of 6 patients (#'s 19, 20, 21, 22, 23, and 26) who arrived at the ED on 6/24/08 not receiving medical evaluation and treatment at the hospital. Additional patients may have been affected. However, since the hospital had placed signs on the doors stating services were not available and since ED personnel did not enter the patient names into the ED Log for	BB298	**Facility Diversion Policy/Procedure** addresses the requirements of a diversion and staff has been informed of the requirements of such. P & P will are available on our computerized system for staff to refer to at all times. **Provider Scheduling P/P and Physician Back up P/P** address the requirements of covering ED 24/7 with physician coverage/back up. **Nursing schedule** assures that there is <u>at least one</u> RN on duty for patient care, 24/7.	9-3-08 9-3-08 9-3-08

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BB298	Continued From page 10 the day in question, it was not possible to confirm or deny that other patients were affected. Having emergency services unavailable delayed assessment, stabilization, and treatment and had the potential to cause negative patient outcomes in all patients who sought care at the ED during the time emergency services were unavailable. The findings include: In an interview on 7/23/08 at 2 PM, the DON confirmed that the hospital went on formal divert status, beginning 8 AM on 6/24/08 until 8 AM on 6/25/08. Patients who arrived at the hospital seeking care were referred by the RN to rural health clinics associated with the hospital and/or to other hospital EDs. A sign was posted on at least 2 entrances to the hospital which stated "Teton Valley Hospital is currently on diversion for our Emergency Services. You can be seen in our [local] Clinics. If it is an emergency, we will make arrangements for you to be transported to [other regional hospitals]." The alternate hospitals were located at distances of 34 to 75 miles away and had to be accessed over mountain roads with an estimated drive time of greater than 45 minutes. This diversion from the ED was confirmed during separate interviews by multiple hospital staff, including the Director of Quality Services, the Director of Clinical Support Services, the CEO, the ED Coordinator, and additional staff RNs. When asked during an interview, on 7/24/08 at 9:45 AM, how and why the diversion happened, the Director of Clinical Support Services explained that there had been a "hole in the ED schedule" for 4 weeks. He said he had been trying for weeks to get the 24-hour shift covered but could not find a physician willing or able to work the shift.	BB298	**BB 298:** Continued. (Page 11 of 16) **We have developed and implemented the following policies/procedures to become compliant with the requirement to have emergency room services available on a daily basis:** **Facility Diversion P/P which provides the requirements, limitations and processes for appropriate facility diversion.** **Provider Scheduling P/P and Physician Back Up P/P: which mandates daily schedules for our ED/Hospitalist and Clinic coverage and the requirements to have 24/7 physician back up/coverage. It also covers time off requirements/limitations.**	9-3-08 9-3-08 9-3-08

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BB298	Continued From page 11 Minutes of a medical staff meeting dated 4/29/08 documented discussion regarding potential scheduling issues. The minutes read as follows: "[name] came to discuss issues with the medical staff scheduling for the ER and [name] and [name] clinics. He did a power point demonstration of areas where the clinic staff was extremely low in numbers and often left clinics with only one provider all day. It appears that the clinic staff is being pulled to cover 24/7 ER coverage, thereby diminishing patient care in the clinics. Review of the situation found it to be more a staffing issue than a scheduling issue as the numbers are not adequate to cover both the ER and the clinic, especially if vacations or time off is requested by anyone. Plans are to meet on May 6th at 7:00 am to discuss scheduling. All providers, including the mid-levels will need to attend or have someone else represent their needs at that meeting. Providers are asked to bring time off requests for vacation, holidays and time off for at least the end of August but preferably for the next 6 months. Holidays need to be decided for the rest of the year if possible. Administration has emphasized that we cannot have all 7 or 8 providers off at the same time because it affects patient care and it is unfair to the providers(s) left to cover. May need to consider flexible dates and non-flexible dates and other possible scheduling models." When asked during an interview on 7/23/08 at 11:30 AM about the the follow-up meeting held on May 6th, the Director of Clinical Support Services stated that an informal "pizza meeting" was held to further discuss the scheduling needs. He stated that he was unable to fill the hole in the schedule on 6/24/08, the day of the diversion. No meeting minutes were reportedly available for the meeting.	BB298	**BB 298:** continued Page 12 of 16) Medical Staff met on Aug 19, 2008 and reviewed and discussed issues relating to Diversion of 6-24-08. Agreed to the formation of the polices as listed below. A need for clarification concerning the statements in the Medical Staff meeting, dated 4-29-08, wherein it was written that a meeting to discuss scheduling was planned for 5-6-08: This was not a medical staff meeting. It was just a informal meeting where in members of the medical staff and their scheduler, met to discuss scheduling issues. It was not a formal medical staff meeting and therefore did not require the taking of minutes	

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BB298	Continued From page 12 During an interview on 7/23/08 at 2:15 PM, RN A, who worked 7 AM to 7 PM in the ED on the day of the diversion (6/24/08), stated she thought "four or five" patients came to the hospital during her shift. She stated that she provided a nursing assessment, including listening to their concerns and taking their vital signs. She then reportedly referred patients to the rural health clinic associated with the hospital for medical evaluation and treatment as the hospital did not have a provider available. The Director of Clinical Support Services provided a list that included the names of five patients (#'s 19, 20, 21, 22, 23, and 24) who arrived at the ED seeking emergency services on 6/24/08 and were subsequently diverted to a rural health clinic associated with the hospital for medical evaluation and treatment. Details regarding the five patients follow. Patient #19 was a 21 year old male who presented to the ED on 6/24/08 at 8:00 AM. The RN documented the patient's vital signs, including a blood pressure of 145/77 and a pulse of 68, in the ED records. The accompanying ED note stated the patient had shot himself in the thumb with a nail gun and that the PA was "coming to see (patient) and then will treat in clinic." The clinic note documented that the PA examined the patient in the ED, cleaned the wound, and then referred the patient to a physician at a hospital 47 miles away. The PA documented the encounter as an "Office Procedure" and the location of care as "OP" (outpatient) at the hospital. While an examination was documented in the ED record, the PA, who was interviewed on 7/22/08 at 4:20 PM, stated she did not provide emergency services to this patient at the hospital on 6/24/08.	BB298	**BB 298:** continued Page 13 of 16) **See Facility Diversion P/P** which provides the requirements, limitations and processes for appropriate facility diversion. P/P developed and implemented **Admission of ED Patient P/P:** which sets the guidelines for how ED patients are admitted into the medical record system. No payment information will be requested until the patient has had a MSE and is stabilized. It also mandates that all patients will be logged in the ED Log book, regardless of the extent of care required **See Emergency Medical Screening Examination P/P** wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record	9-3-08 9-3-08 9-3-08

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BB298	Continued From page 13 Patient #20 was a 19 year old female who presented to the ED on 6/24/08 at 5:45 PM. The RN documented the patient's vital signs, including a blood pressure 162/93 and a pulse of 104, in the ED record. The accompanying ED note stated the patient "walked in (complaining of) 'stomach upset' spitting blood [with] was directed to a rural health clinic associated with the hospital. The PA documented in the clinic note, dated 6/24/08, that the patient complained of "coughing up blood and mucus for about a week, a couple times a day." She was diagnosed with "GASTRITIS NEC W/HEMORRHAGE". Further tests (laboratory, ultrasound) were recommended at other facilities. No documentation was found to indicate the hospital provided medical evaluation or treatment prior to diverting Patient #20 to the rural health clinic. Patient #21 was an 8 year old female who presented to the ED on 6/24/08 with an achy body and a fever. No documentation was found as to the time of arrival in the ED. The clinic note, dated 6/24/08, documented a nursing assessment at 5:17 PM. The clinic note further documented that the patient was treated for an ear infection and sent home with instructions to return to the clinic in one day. No documentation was found to indicate the hospital provided medical evaluation or treatment prior to diverting Patient #21 to the rural health clinic. Patient #22 was a 30 year old female who presented to the ED on 6/24/08 with a swollen foot after a bicycle accident the previous day. No documentation was found as to the time of arrival in the ED. The clinic note, dated 6/24/08 documented a nursing assessment at 5:44 PM. The clinic note further documented the x-ray results were negative for a fracture and that the	BB298	**BB 298: continued Page 14 of 16)** **See Emergency Medical Screening Examination P/P wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record** **Admission of ED Patient P/P: which sets the guidelines for how ED patients are admitted into the medical record system. No payment information will be requested until the patient has had a MSE and is stabilized. It also mandates that all patients will be logged in the ED Log book, regardless of the extent of care required**	9-3-08 9-3-08

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB298	Continued From page 14 patient was sent home with instructions for how to manage pain and swelling and further advised to return to the clinic if symptoms continued or worsened. No documentation was found to indicate the hospital provided evaluation and treatment prior to diverting Patient #22 to the rural health clinic. Patient #23 was a 31 year old female who presented to the ED on 6/24/08 with a wound to her foot after having stepped on a garden rake. No documentation was found in the clinical record as to the time of arrival in the ED. A clinic note, dated 6/24/08 documented a nursing assessment at 10:54 AM. The clinic note further documented: 1) the patient's wound was treated; 2) she was given a tetanus shot; 3) she was sent home with instructions to return to the clinic in one day for a wound check and wound care instructions. No documentation was found to indicate the hospital provided evaluation and treatment prior to diverting Patient #23 to the rural health clinic. An additional unknown patient (#26) was reportedly diverted away from the ED after seeking emergency care. During an interview on 7/23/08 at 2:37 PM, RN B, who worked 7 PM to 7 AM during the diversion on 6/24/08 and 6/25/08, stated that one adult female patient complaining of abdominal pain arrived at the ED during her shift. The RN stated: 1) she did not take the patient's vital signs; 2) she did not do any hands-on assessment; 3) she did not get the woman's name; 4) she told the patient that no physician was available to see her in the hospital and that she (the patient) could go to another hospital or be seen in the clinic in the morning. The patient reportedly left with her husband to find another emergency facility. No ED clinical	BB298	**BB 298:** continued Page 15 of 16) See **Emergency Medical Screening Examination P/P** wherein it addresses who needs an MSE, who is qualified to do it, and that it shall be documented on the ED Record **Admission of ED Patient P/P:** which sets the guidelines for how ED patients are admitted into the medical record system. No payment information will be requested until the patient has had a MSE and is stabilized. It also mandates that all patients will be logged in the ED Log book, regardless of the extent of care required.	9-3-08 9-3-08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131313	A. BUILDING _____ B. WING _____	C 07/30/2008

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BB298	Continued From page 15 record was found to confirm or deny the information provided by the RN. During an interview on 7/24/08 at 9:30 AM, the Director of Quality Services denied that any formal analysis had been done by the hospital related to the diversion that occurred on 6/24/08. She denied that any policies or procedures regarding going on diversion were in place prior to the diversion, nor had any new policies and procedures relating to the diversion been established since the diversion. She also denied that any performance improvement activities had been initiated related to the diversion. Similarly, during an interview on 7/23/08 at 11:35 AM, the Director of Clinical Support Services stated that no formal meetings had been held and no specific action had been taken to prevent the need for the hospital to go on divert in the future. He also stated that no action had been taken to ensure patients would be provided with appropriate MSEs should the hospital go on divert again. In summary, the agency failed to provide sufficient medical staff to ensure the availability of 24-hour emergency services.	BB298	**BB298**: (Page 16 of 16) Policies and procedures have been developed, with the assistance of the CEO, which address all of the allegations within this document. Policies are as follows: **1. Administrator On-Call P/P** **2. Facility Diversion P/P** **3. Provider Scheduling P/P** **4. Emergency Medical Screening Examination P/P** **5. Admission of the ED Patient P/P** **6. Director of Nursing Services Designee P/P** **7. Physician Back up P/P** Implementation is evidenced by: 1. Creation of the above-listed policies and procedures. 2. Physician Schedule and RN schedule being posted with backup assured on a continuous basis. 3. AOC Training 4. AOC Log Book implementation 5. Development of Crisis Calling Checklist 6. ED Admission Training 7. Notification to Patient concerning Provider Coverage 24/7. 8. Quality Improvement review project to assure ED patients are being placed on the ED log, and also checking to assure MSEs are done on all ER patients. Medical Staff met on Aug 19, 2008 and reviewed and discussed issues relating to Diversion of 6-24-08. Agreed to the formation of the polices as listed above.. Meeting was held with the Board on 9-25-08 to discuss and approve the above policies and procedures to address the concerns as listed herein and to review the problems with the diversion of 6-24-08.	9-3-08